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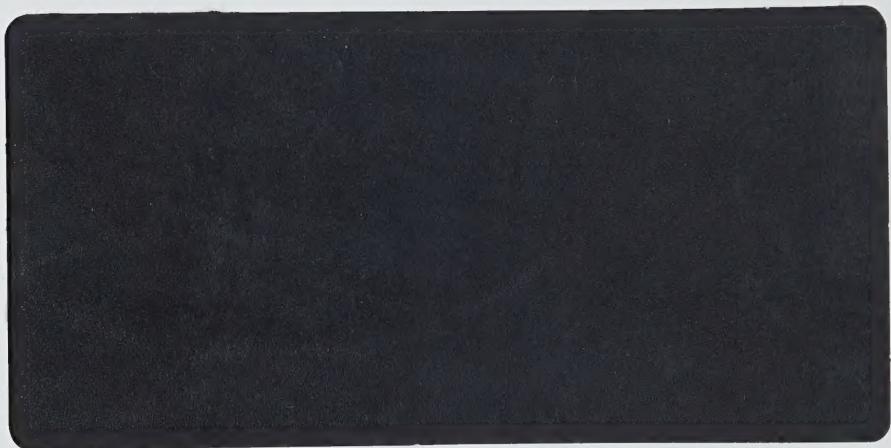


IMPACT OF CHILD SEXUAL ABUSE: A REVIEW OF THE RESEARCH

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IMPACT OF CHILD SEXUAL ABUSE: A REVIEW OF THE RESEARCH

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This article reviews studies that have tried to confirm empirically the effects of child sexual abuse cited in the clinical literature. In regard to initial effects, empirical studies have indicated reactions -- in at least some portion of the victim population -- of fear, anxiety, depression, anger and hostility, aggression and sexually inappropriate behavior. Frequently reported long-term effects include depression and self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency toward revictimization, substance abuse and sexual maladjustment. The kinds of abuse that appear to be most damaging according to the empirical studies, are experiences involving father figures, genital contact and force. The controversy over the impact of child sexual abuse is discussed and recommendations for future research efforts are suggested.

Although clinical literature suggests that sexual abuse during childhood plays a role in the development of other problems ranging from anorexia nervosa to prostitution, empirical evidence about its actual effects is sparse. In this article we review the expanding empirical literature on the effects of child sexual abuse, discuss its initial and long-term effects, review studies on the impact of different kinds of abuse and conclude with a critique of the current literature and some suggestions for future research.

Child sexual abuse consists of two overlapping but distinguishable types of interaction: (a) forced or coerced sexual behavior imposed on a child, and (b) sexual activity between a child and a much older person, whether or not obvious coercion is involved (a common definition of "much older" is 5 or more years). As might be expected, not all studies relevant to

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our purposes share these parameters. Some have focused on experiences with older partners only, excluding coerced sexual experiences with peers. Others have looked only at sexual abuse that was perpetrated by family members. Such differences in samples make comparisons among these studies difficult. However, we include all the studies that looked at some portion of the range of experiences that are bounded by these two criteria. (See Table 1 for a breakdown of sample composition of the studies reviewed.)

Two areas of the literature are not included in our review. A small number of studies on the effects of incest (e.g., Farrell, 1982; Nelson, 1981), as well as one review of the effects of child sexual experiences (Constantine, 1980), combine data on consensual, peer experiences with data that involve either coercion or age disparity. Because we were unable to isolate sexual abuse in these studies, we had to exclude them. Secondly, we decided to limit our review to female victims. Few clinical and even fewer empirical, studies have been done on male victims (for exceptions see Finkelhor, 1979; Rogers and Terry, 1984; Sandfort, 1981; Woods and Dean, 1984) and it seems premature to draw conclusions at this point.¹ Under "empirical" studies, we include any research that attempted to quantify the extent to which a sequelae to sexual abuse appeared in a specific population. Some of these studies used objective measures, whereas others were based primarily on the judgments of clinicians.

Initial Effects

By initial effects, we mean those reactions occurring within 2 years of the termination of abuse. These early reactions are often called **short-term** effects in the literature. We prefer the term **initial** effects, however, because "short-term" implies that the reactions do not persist -- an assumption that has yet to be substantiated.

Emotional Reactions and Self-Perceptions

Although several empirical studies have given support to clinical observations of generally negative emotional effects resulting from childhood sexual abuse, only two used standardized measures and compared subjects' scores to general population norms. In an early study of the effects of sexual abuse on children, DeFrancis (1969) reported that 66% of the victims were emotionally disturbed by the molestation: 52% mildly to moderately disturbed and 14% seriously disturbed. Only 24% were judged to be emotionally stable after the abuse. However, because this sample was drawn from court cases known to Prevention of Cruelty to Children services or to the police and

¹The whole literature on sexual abuse poses problems for differentiating according to gender of victims. As Table 1 shows, many studies contain a small number of men included in a larger sample of women. Unfortunately, many of these studies do not specifically mention which effects apply to men, so it is possible that some of the sequelae described apply only to the men. However, we believe that most of the sequelae described relate primarily to women.

because the subjects came primarily from low income and multiple-problem families who were on public assistance, these findings may have little generalizability.

In investigating a different type of special population, Anderson, Bach and Griffith (1981) reviewed clinical charts of 155 female adolescent sexual assault victims who had been treated at the Harborview Center in Washington and reported psychosocial complications in 63% of them. Reports of "internalized psychosocial sequelae" (e.g., sleep and eating disturbances, fears and phobias, depression, guilt, shame and anger) were noted in 67% of female victims when the abuse was intrafamilial and 49% when the offender was not a family member. "Externalized sequelae" (including school problems and running away) were noted in 66% of intrafamilial victims and 21% of extrafamilial victims. However, no standardized outcome measures were used, so the judgments of these effects may be subjective.

In what is probably the best study to date, researchers affiliated with the Division of Child Psychiatry at the Tufts New England Medical Center gathered data on families involved in a treatment program restricted to those children who had been victimized or revealed their victimization in the prior 6 months. Standardized self-report measures -- the Louisville Behavior Checklist (LBC), the Piers-Harris Self-Concept Scale, the Purdue Self- Concept Scale and the Gottschalk Glessner Content Analysis Scales (GGCA) -- with published norms and test validation data were used, so that characteristics of sexually abused children could be contrasted with norms for general and psychiatric populations. Subjects ranged in age from infancy to 18 years and were divided into preschool, latency and adolescence age groups. Data were gathered on four areas: overt behavior, somaticized reactions, internalized emotional states and self-esteem.

In evaluating the initial psychological effects of child sexual abuse, Tufts (1984) researchers found differences in the amount of pathology reported for different age groups. Seventeen percent of 4- to 6-year-olds in the study met the criteria for "clinically significant pathology," demonstrating more overall disturbance than a normal population but less than the norms for other children their age who were in psychiatric care. The highest incidence of psychopathology was found in the 7- to 13-year-old age group, with 40% scoring in the seriously disturbed range. Interestingly, few of the adolescent victims exhibited severe psychopathology, except on a measure of neuroticism.

Friedrich, Urquiza and Beilke (in press) also used a standardized measure in their study of 61 sexually abused girls. Subjects were referred by a local sexual assault center for evaluation or by the outpatient department of a local hospital. Children in this sample had been abused within a 24-month period prior to the study. Using the Child Behavior Check List (CBCL; see Achenbach and Edelbrock, 1983, for a description of this measure), Friedrich et al., reported that 46% of their subjects had significantly elevated scores on its Internalizing scale (including fearful, inhibited, depressed and overcontrolled behaviors) and 39% had elevated scores on its Externalizing scale (aggressive, antisocial and undercontrolled behaviors). This was compared with only 2% of the normative sample who would be expected to score in this range. Younger children (up to age 5) demonstrated a

Table 1
Studies of Effects of Sexual Abuse

Study	Source of sample	N	Gender	Age of respondents	Focus of study	Comparison group
Anderson, Bach and Griffith, 1981	Sexual assault center	277	F = 155 M = 72	Ad	I, E	No
Bagley and Ramsay, 1985	Random sample	679	F = 401 M = 278	A	I, E	Yes
Benward and Densen-Gerber, 1975	Drug treatment center	118	F = 118	Ad, A	I	No
Briere, 1984	Community health center	153	F = 153	A	I, E	Yes
Briere and Runtz, 1985	College students	278	F = 278	Ad, A	I, E	Yes
Courtois, 1979	Ads and mental health agencies	31	F = 31	A	I	No
DeFrancis, 1969	Court cases	250	F = 217 M = 33	C, Ad	I, E	No
DeYoung, 1982	College students, therapy patients, and others	80	F = 72 M = 8	C, Ad, A	I	No
Fields, 1981	Prostitutes recruited after arrest	85	F = 85	A	I	Yes
Finkelhor, 1979	College students	796	F = 530 M = 266	Ad, A	I, E	Yes
Friedrich, Urquiza and Beilke(in press)	Sexual assault center, group therapy	64	F = 49 M = 15	C	I, E	No
Fromuth, 1983	College students	482	F = 482	Ad, A	I, E	Yes
Harrison, Lumry and Claypatch, 1984	Dual disorder treatment program	62	F = 62	A	I, E	Yes
Herman, 1981	Clients in therapy	60	F = 60	Ad, A	I	Yes
James and Meyerding, 1977	Prostitutes selected from arrest records					
Study 1		92	F = 92	Ad, A	I, E	No
Study 2		136	F = 136	A	I, E	No
Landis, 1956	College students	950	F = 726 M = 224	A	I, E	Yes
Langmade, 1983	Mental health centers, private clinics	68	F = 68	A	I	Yes
Meiselman, 1978	Clinical records, psychiatric clinic	108	F = 97 M = 11	C, Ad, A	I	Yes
Peters, J., 1976	Rape crisis center	100	-	C	I	No
Peters, S., 1984	Follow-up, community random sample	119	F = 119	A	I, E	Yes
Russell, in press	Random sample	930	F = 930	A	I, E	Yes
Sedney and Brooks, 1984	College students	301	F = 301	Ad, A	I, E	Yes
Seidner and Calhoun, 1984	College students	152	F = 118 M = 34	A	I, E	Yes
Silbert and Pines, 1981	Prostitutes recruited by ads	200	F = 200	Ad, A	I, E	No
Tsai, Feldman-Summers and Edgar 1979	Ads	90	F = 90	A	I, E	Yes
Tufts Study, 1984	Clinical referrals	156	F = 122 M = 34	C, Ad	I, E	No

Note F = female and M = male, C = child, Ad = adolescent and A = adult
I = intrafamilial and E = extrafamilial

tendency to score high on the Internalizing scale, whereas older children (ages 6-12) were more likely to have elevated scores on the Externalizing scale.

Breaking down emotional impact into specific reactions, we find that the most common initial effect noted in empirical studies, similar to reports in the clinical literature, is that of fear. However, exact proportions vary from a high of 83% reported by DeFrancis (1969) to 40% reported by Anderson et al., (1981). Because of its use of standardized measures, we would give the most credence to the Tufts (1984) study, which found that 45% of the 7- to 13-year-olds manifested severe fears as measured by the LBCs, compared with 13% of the 4- to 6-year-olds. On the adolescent version of the LBC, 36% of the 14- to 18-year-olds had elevated scores on "ambivalent hostility", or the fear of being harmed.

Another initial effect in children is reactions of anger and hostility. Tufts (1984) researchers found that 45% to 50% of the 7- to 13-year-olds showed hostility levels that were substantially elevated on measures of aggression and antisocial behavior (LBC), as did 35% on the measure of hostility directed outward (GGCA). Thirteen percent to 17% of 4- to 6-year-olds scored above the norms on aggression and antisocial behavior (LBC), whereas 25% of 4- to 6-year-olds and 23% of the adolescents had elevated scores on hostility directed outward (GGCA). In his study of court cases, DeFrancis (1969) noted that 55% of the children showed behavioral disturbances such as active defiance, disruptive behavior within the family and quarreling or fighting with siblings or classmates. DeFrancis' sample might have been thought to overselect for hostile reactions; however, these findings are not very different from findings of the Tufts study for school-age children.

Guilt and shame are other frequently observed reactions to child sexual abuse, but few studies give clear percentages. DeFrancis (1969) observed that 64% of his sample expressed guilt, although this was more about the problems created by disclosure than about the molestation itself. Anderson et al., (1981) reported guilt reactions in 25% of the victims. Similarly, depression is frequently reported in the clinical literature, but here too, specific figures are rarely given. Anderson et al., (1981) found that 25% of female sexual assault victims were depressed after the abuse.

Sexual abuse is also cited as having an effect on self-esteem, but this effect has not yet been established by empirical studies. Fifty-eight percent of the victims in the DeFrancis (1969) study expressed feelings of inferiority or lack of worth as a result of having been victimized. However, in a surprising finding, Tufts (1984) researchers, using the Purdue Self-Concept Scale, found no evidence that sexually abused children in any of the age groups had consistently lower self-esteem than a normal population of children.

Physical Consequences and Somatic Complaints

Physical symptoms indicative of anxiety and distress are noted in the empirical literature as well as in clinical reports. In their chart review of female adolescent victims, Anderson et al., (1981) found that 17% had

experienced sleep disturbances and 5% - 7% showed changes in eating habits after the victimization. J. Peters (1976), in a study of child victims of intrafamilial sexual abuse, reported that 31% had difficulty sleeping and 20% experienced eating disturbances. However, without a comparison group, it is hard to know if this is seriously pathological for any group of children, or for clinical populations in particular. Adolescent pregnancy is another physical consequence sometimes mentioned in empirical literature. DeFrancis (1969) reported that 11% of the child victims in his study became pregnant as a result of the sexual offense; however, this figure seems far too high for a contemporary sample. Meiselman (1978), in analyzing records from a Los Angeles psychiatric clinic, found only 1 out of 47 incest cases in which a victim was impregnated by her father.

Effects of Sexuality

Reactions of inappropriate sexual behavior in child victims have been confirmed by two studies using standardized measures (Friedrich et al., in press: Tufts, 1984). In the Tufts (1984) study, 27% of 4- to 6-year-old children scored significantly above clinical and general population norms on a sexual behavior scale that included having had sexual relations (possibly a confounding variable in these findings), open masturbation, excessive sexual curiosity and frequent exposure of the genitals. Thirty-six percent of the 7- to 13-year-olds also demonstrated high levels of disturbance on the sexual behavior measure when contrasted to norms for either general or clinical school-age populations. Similarly, Friedrich et al. (in press), using the CBCL to evaluate 3- to 12-year-olds, found that 70% of the boys and 44% of the girls scored at least one standard deviation above a normal population of that age group on the scale measuring sexual problems. Interestingly, sexual problems were most common among the younger girls and the older boys.

Effects on Social Functioning

Other aftereffects of child sexual abuse mentioned in the literature include difficulties at school, truancy, running away from home and early marriages by adolescent victims. Herman (1981) interviewed 40 patients in therapy who had been victims of father-daughter incest and compared their reports with those from a group of 20 therapy clients with seductive, but not incestuous, fathers. Of the incest victims, 33% attempted to run away as adolescents, compared with 5% of the comparison group. Similarly, Meiselman (1978) found that 50% of the incest victims in her sample had left home before the age of 18, compared with 20% of women in a comparison group of nonvictimized female patients. Younger children often went to a relative, whereas older daughters ran away or eloped, sometimes making early marriages in order to escape the abuse. Two studies, neither with comparison groups, mentioned school problems and truancy. Ten percent of the child victims in J. Peter's (1976) study quit school, although all of his subjects were under the age of 12 at the time. Anderson et al., found that 20% of the girls in their sample experienced problems at school, including truancy or dropping out.

A connection between sexual abuse, running away and delinquency is also suggested by several studies of children in special treatment or delinquency programs. Reich and Gutierrez (1979) reported that 55% of the children in Maricopa County, Arizona who were charged with running away, truancy, or

listed as missing persons were incest victims. In addition, in a study of female juvenile offenders in Wisconsin (1982), researchers found that 32% had been sexually abused by a relative or other person close to them.

Summary of Initial Effects of Child Sexual Abuse

The empirical literature on child sexual abuse, then, does suggest the presence -- in some portion of the victim population -- of many of the initial effects reported in the clinical literature, especially reactions of fear, anxiety, depression, anger and hostility and inappropriate sexual behavior. However, because many of the studies lacked standardized outcome measures and adequate comparison groups, it is not clear that these findings reflect the experience of all child victims of sexual abuse or are even representative of those children currently being seen in clinical settings. At this point, the empirical literature on the initial effects of child sexual abuse would have to be considered sketchy.

Long-Term Effects

Emotional Reactions and Self-Perceptions

In the clinical literature, depression is the symptom most commonly reported among adults molested as children and empirical findings seem to confirm this. Two excellent community studies are indicative of this. Bagley and Ramsay (1985), in a community mental health study in Calgary utilizing a random sample of 387 women, found that subjects with a history of child sexual abuse scored more depressed on the Centre for Environmental Studies Depression Scale (CES-D) than did nonabused women (17% vs. 9% with clinical symptoms of depression in the last week), as well as on the Middlesex Hospital Questionnaire's measure of depression (15% vs. 7%). S. Peters (1984), in a community study in Los Angeles also based on a random sample, interviewed 119 women and found that sexual abuse in which there was physical contact was associated with a higher incidence of depression and a greater number of depressive episodes over time and that women who had been sexually abused were more likely to have been hospitalized for depression than nonvictims. In a multiple regression that included both sexual abuse and family background factors (e.g., a poor relationship with the mother), the variable of child sexual abuse made an independent contribution to depression.

The link between child sexual abuse and depression has been confirmed in other nonclinical samples as well. Sedney and Brooks (1984), in a study of 301 college women, found a greater likelihood for subjects with childhood sexual experiences to report symptoms of depression (65% vs. 43% of the control group) and to have been hospitalized for it (18% of those depressed in the childhood experience group vs. 4% of women in the control group). These positive findings are surprising, in that the researchers used an overly inclusive definition of sexual experiences that may not have screened out some consensual experiences with peers. Their results are consistent, however, with those from a carefully controlled survey of 278 undergraduate women by Briere and Runtz (1985) using 72 items of the Hopkins Symptom Checklist, which indicated that sexual abuse victims reported that they experienced more depressive symptoms during the 12 months prior to the study than did nonabused subjects.

Studies based on clinical samples (Herman, 1981; Meiselman, 1978) have not shown such clear differences in depression between victims and nonvictims. For example, although Herman (1981) noted major depressive symptoms in 60% of the incest victims in her study, 55% of the comparison group also reported depression. Meiselman (1978) reported depressive symptoms in 35% of the incest victims whose psychiatric records she reviewed, compared with 23% of the comparison group; again, this difference was not significant.

Both clinical and nonclinical samples have shown victims of child sexual abuse to be more self-destructive, however. In an extensive study of 153 "walk-ins" to a community health counseling center, Briere (1984) reported that 51% of the sexual abuse victims, versus 34% of nonabused clients, had a history of suicide attempts. Thirty-one percent of victims, compared with 19% of nonabused clients, exhibited a desire to hurt themselves. A high incidence of suicide attempts among victims of child sexual abuse has been found by other clinical researchers as well (e.g., Harrison, Lumry and Claypatch, 1984; Herman, 1981). Bagley and Ramsay (1985), in their community study, noted an association between childhood sexual abuse and suicide ideation or deliberate attempts at self-harm. And Sedney and Brooks (1984) found that 39% of their college student sample with child sexual experiences reported having thoughts of hurting themselves compared with 16% of the control group. Sixteen percent of these respondents had made at least one suicide attempt (vs. 6% of their peers).

Another reaction observed in adults who were sexually victimized as children is symptoms of anxiety or tension. Briere (1984) reported that 54% of the sexual abuse victims in his clinical sample experienced anxiety attacks (compared with 28% of the nonvictims), 54% reported nightmares (vs. 23%) and 72% had difficulty sleeping (compared with 55% of the nonvictims). In their college sample, Sedney and Brooks (1984) found 59% with symptoms indicating nervousness and anxiety (compared with 41% of the controls); 41% indicated extreme tension (vs. 29% of the controls) and 51% had trouble sleeping (compared with 29% of the controls). These findings are supported by results from community samples, with Bagley and Ramsay (1985) noting that 19% of their subjects who had experienced child sexual abuse reported symptoms indicating somatic anxiety on the Middlesex Hospital Questionnaire, compared with 9% of the nonabused subjects.

The idea that sexual abuse victims continue to feel isolated and stigmatized as adults also has some support in the empirical literature, although these findings come only from the clinical populations. Sixty-four percent of the victimized women in Briere's (1984) study reported feelings of isolation, compared with 49% of the controls. With incest victims, the figures are even higher: Herman (1981) reported that all of the women who had experienced father-daughter incest in her clinical sample had a sense of being branded, marked or stigmatized by the victimization. Even in a community sample of incest victims, Courtois (1979) found that 73% reported they still suffered from moderate to severe feelings of isolation and alienation.

Although a negative self-concept was not confirmed as an initial effect, evidence for it as a long-term effect is much stronger. Bagley and Ramsay (1985) found that 19% of the child sexual abuse victims in their random

sample scored in the "very poor" category on the Coopersmith self-esteem inventory (vs. 5% of the control group), whereas only 9% of the victims demonstrated "very good" levels of self-esteem (compared with 20% of the controls). Women with very poor self-esteem were nearly four times as likely to report a history of child sexual abuse as were the other subjects. As might be expected, self-esteem problems among clinical samples of incest victims tended to be much greater: Eighty-seven percent of Courtois's (1979) community sample reported that their sense of self had been moderately to severely affected by the experience of sexual abuse from a family member. Similarly, Herman (1981) found that 60% of the incest victims in her clinical sample were reported to have a "predominantly negative self-image", as compared with 10% of the comparison group with seductive but not incestuous fathers.

Impact on Interpersonal Relating

Women who have been sexually victimized as children report problems in relating both to women and men, continuing problems with their parents and difficulty in parenting and responding to their own children. In DeYoung's (1982) sample, 79% of the incest victims had predominantly hostile feelings toward their mothers, whereas 52% were hostile toward the abuser. Meiselman (1978) found that 60% of the incest victims in her psychotherapy sample disliked their mothers and 40% continued to experience strong negative feelings toward their fathers. Herman (1981) also noted that the rage of incest victims in her sample was often directed toward the mother and observed that they seemed to regard all women, including themselves, with contempt.

In addition, victims reported difficulty trusting others that included reactions of fear, hostility and a sense of betrayal. Briere (1984) noted fear of men in 48% of his clinical subjects (vs. 15% of the nonvictims) and fear of women in 12% (vs. 4% of those who had not been sexually victimized). Incest victims seem especially likely to experience difficulty in close relationships: Sixty-four percent of the victims in Meiselman's (1978) clinical study, compared with 40% of the control group, complained of conflict with or fear of their husbands or sex partners and 39% of the sample had never married. These results are supported by findings from Courtois's (1979) sample, in which 79% of the incest victims experienced moderate or severe problems in relating to men and 40% had never married.

There is at least one empirical study that lends support to the idea that childhood sexual abuse also affects later parenting. Goodwin, McCarthy and Divasto (1981) found that 24% of mothers in the child abusing families they studied reported incest experiences in their childhoods, compared with 3% of a nonabusive control group. They suggested that difficulty in parenting results when closeness and affection is endowed with a sexual meaning and observed that these mothers maintained an emotional and physical distance from their children, thus potentially setting the stage for abuse.

Another effect on which the empirical literature agrees is the apparent vulnerability of women who have been sexually abused as children to be revictimized later in life. Russell (in press), in her probability sample of 930 women, found that between 33% and 68% of the sexual abuse victims

(depending on the seriousness of the abuse they suffered) were raped later on, compared with 17% of women who were not childhood victims. Fromuth (1983), in surveying 482 female college students, found evidence that women who had been sexually abused before the age of 13 were especially likely to later become victims of nonconsensual sexual experiences. Further evidence of a tendency toward revictimization comes from a study conducted at the University of New Mexico School of Medicine on 341 sexual assault admittances (Miller et al., 1978). In comparing women who had been raped on more than one occasion with those who were reporting a first-time rape, researchers found that 18% of the repeat victims had incest histories, compared with only 4% of first-time victims.

In addition to rape, victims of child sexual abuse also seem more likely to be abused later by husbands or other adult partners. Russell (in press) found that between 38% and 48% of the child sexual abuse victims in her community sample had physically violent husbands, compared with 17% of women who were not victims; in addition, between 40% and 62% of the abused women had later been sexually assaulted by their husbands, compared with 21% of non-victims. Similarly, Briere (1984) noted that 49% of his clinical sexual abuse sample reported being battered in adult relationships, compared with 18% of the nonvictim group.

Effects on Sexuality

One of the areas receiving the most attention in the empirical literature on long-term effects concerns the impact of early sexual abuse on later sexual functioning. Almost all clinically based studies show later sexual problems among child sexual abuse victims, particularly among the victims of incest. However, there have not yet been community-based studies on the sexual functioning of adults molested as children, as there have been of other mental health areas such as depression.

Of the clinical studies, Meiselman (1978) found the highest percentage of incest victims reporting problems with sexual adjustment. Eighty-seven percent of her sample were classified as having had a serious problem with sexual adjustment at some time since the molestation, compared with 20% of the comparison group (women who had been in therapy at the same clinic, but had not been sexually victimized as children). Results from Herman's (1981) study are somewhat less extreme: Fifty-five percent of the incest victims reported later sexual problems, although they were not significantly different from women with seductive fathers on this measure. Langmade (1983) compared a group of women in therapy who had been incest victims with a matched control group of nonvictimized women and found that the incest victims were more sexually anxious, experienced more sexual guilt and reported greater dissatisfaction with their sexual relationships than the controls. In his study of a walk-in sample to a community health clinic, Briere (1984) found that 45% of women who had been sexually abused as children reported difficulties with sexual adjustment as adults, compared with 15% of the control group. Briere also noted a decreased sex drive in 42% of the victims studied, versus 29% of the nonvictims.

Two nonclinical studies show effects on sexual functioning as well. Courtois noted that 80% of the former incest victims in her sample reported an inability to relax and enjoy sexual activity, avoidance of or abstention from sex, or, conversely, a compulsive desire for sex. Finkelhor (1979), studying college students, developed a measure of sexual self-esteem and found that child sexual abuse victims reported significantly lower levels of sexual self-esteem than their nonabused classmates. However, Fromuth (1983), in a similar study also with a college student sample, found no correlation between sexual abuse and sexual self-esteem, desire for intercourse, or students' self-ratings of their sexual adjustment. Virtually all (96%) of Fromuth's respondents were unmarried and their average age was 19, so it is possible that some of the long-term sexual adjustment problems reported by women in the clinical and community samples were not yet in evidence in this younger population. Still, this does not explain the discrepancy from the Finkelhor findings.

In another study, Tsai, Feldman-Summers and Edgar (1979) compared three groups of women on sexual adjustment measures: sexual abuse victims seeking therapy, sexual abuse victims who considered themselves well-adjusted and had not sought therapy and a nonvictimized matched control group. Results indicated that the "well-adjusted" victims were not significantly different from the control group on measures of overall and sexual adjustment, but the victims seeking therapy did show a difference. They experienced orgasm less often, reported themselves to be less sexually responsive, obtained less satisfaction from their sexual relationships, were less satisfied with the quality of their close relationships with men and reported a greater number of sexual partners. It is hard to know how to interpret findings from a group of victims solicited on the basis of feeling "well-adjusted". This seems far different from a comparison group of victims who were not in therapy and thus these results are questionable.

A long-term effect of child sexual abuse that has also received a great deal of attention in the literature is an increased level of sexual behavior among victims, usually called promiscuity (e.g., Courtois, 1979; DeYoung, 1982; Herman, 1981; Meiselman, 1978). Herman noted that 35% of the incest victims in her sample reported promiscuity and observed that some victims seemed to have a "repertoire of sexually stylized behavior" that they used as a way of getting affection and attention (p. 40). DeYoung (1982) reported that 28% of the victims in her sample had engaged in activities that could be considered promiscuous; Meiselman (1978) found 25%. However, in her study of 482 female college students, Fromuth (1983) found no differences in this variable and observed that having experienced child sexual abuse only predicted whether subjects would describe themselves as promiscuous, not their actual number of partners. This potentially very important finding suggests that the "promiscuity" of sexual abuse victims may be more a function of their negative self-attributions, already well documented in the empirical literature, than their actual sexual behavior; thus researchers should be careful to combine objective behavioral measures with this type of self-report.

Another question that has received comment but little empirical confirmation concerns the possibility that sexual abuse may be associated with later homosexuality in victims. Although one study of lesbians found molestation in

their backgrounds (Gundlach, 1977), Bell and Weinberg (1981), in a large-scale, sophisticated study of the origin of sexual preference, found no such association. Studies from the sexual abuse literature have also found little connection (Finkelhor, 1984; Fromuth, 1983; Meiselman, 1978).

Effects on Social Functioning

Several studies of special populations suggest a connection between child sexual abuse and later prostitution. James and Meyerding (1977) interviewed 136 prostitutes and found that 55% had been sexually abused as children by someone 10 or more years older, prior to their first intercourse. Among adolescents in the sample, 65% had been forced into sexual activity before they were 16-years old. Similarly, Silbert and Pines (1981) found that 60% of the prostitutes they interviewed had been sexually abused before the age of 16 by an average of two people for an average of 20 months. (The mean age of these children at the time of their first victimization was 10.) They concluded that, "The evidence linking juvenile sexual abuse to prostitution is overwhelming" (p. 410). However, Fields (1981) noted that although 45% of the prostitutes in her sample had been sexually abused as children, this did not differentiate them from a comparison group of nonprostitutes matched on age, race and education, of which 37% had been abused. Although there was no difference in prevalence between the two groups, Fields did find that the prostitutes were sexually abused at a younger age -- 14.5 versus 16.5 -- and were more apt to have been physically forced.

An association between child sexual abuse and later substance abuse has also received empirical support. S. Peters (1984), in a carefully controlled community study, found that 17% of the victimized women had symptoms of alcohol abuse (vs. 4% of nonvictimized women) and 27% abused at least one type of drug (compared with 12% of nonvictimized women). Herman (1981) noted that 35% of the women in her clinical sample with incestuous fathers abused drugs and alcohol (vs. 5% of the women with seductive fathers). Similarly, Briere (1984), in his walk-in sample from a community health center, found that 27% of the childhood sexual abuse victims had a history of alcoholism (compared with 11% of nonvictims) and 21% had a history of drug addiction (vs. 2% of the nonvictims). College student samples appear more homogeneous: Sedney and Brooks (1984) found a surprisingly low reported incidence of substance abuse and no significant differences between groups.

Summary of Long-Term Effects

Empirical studies with adults confirm many of the long-term effects of sexual abuse mentioned in the clinical literature. Adult women victimized as children are more likely to manifest depression, self-destructive behavior, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimization and substance abuse. Difficulty in trusting others and sexual maladjustment in such areas as sexual dysphoria, sexual dysfunction, impaired sexual self-esteem and avoidance of or abstention from sexual activity have also been reported by empirical researchers, although agreement between studies is less consistent for the variables on sexual functioning.

Impact of Sexual Abuse

In light of the studies just reviewed, it is appropriate to evaluate the persistent controversy over the impact of sexual abuse on victims. It has been the continuing view of some that sexual abuse is not traumatic or that its traumatic impact has been greatly overstated (Constantine, 1977; Henderson, 1983; Ramey, 1979). Proponents of this view contend that the evidence for trauma is meager and based on inadequate samples and unwarranted inferences. Because of the general lack of research in this field, clinicians have only recently been able to substantiate their impressions that sexual abuse is traumatic with evidence from strong scientific studies. However, as evidence now accumulates, it conveys a clear suggestion that sexual abuse is a serious mental health problem, consistently associated with very disturbing subsequent problems in some important portion of its victims.

Findings of long-term impact are especially persuasive. Eight non-clinical studies of adults (Bagley and Ramsay, 1985; Briere and Runtz, 1985; Finkelhor, 1979; Fromuth, 1983; S. Peters, 1984; Russell, in press; Sedney and Brooks, 1984; Seidner and Calhoun, 1984), including three random sample community surveys, found that child sexual abuse victims in the "normal" population had identifiable degrees of impairment when compared with nonvictims. Although impairments in these nonclinical victims are not necessarily severe, all the studies that have looked for long-term impairment have found it, with the exception of one (Tsai et al., 1979).

These findings are particularly noteworthy in that the studies were identifying differences associated with an event that occurred from 5 to 25 years previously. Moreover, all these studies used fairly broad definitions of sexual abuse that included single episodes, experiences in which no actual physical contact occurred and experiences with individuals who were not related to or emotionally close to the subjects. In all four studies that used multivariate analyses (Bagley and Ramsay 1985; Finkelhor, 1984; Fromuth, 1983; S. Peters, 1984), differences in the victimized group remained after a variety of background and other factors had been controlled. The implication of these studies is that a history of childhood sexual abuse is associated with greater risk for mental health and adjustment problems in adulthood.

Unfortunately, although the studies indicate higher risk, they are not so informative about the actual extent of impairment. In terms of simple self-assessments, 53% of intrafamilial sexual abuse victims in Russell's (in press) community survey reported that the experience resulted in "some" or "great" long-term effects on their lives. Assessments with standardized clinical measures show a more modest incidence of impairment: In Bagley & Ramsay's (1985) community survey, 17% of sexual abuse victims were clinically depressed as measured by the CES-D and 18% were seriously psychoneurotic. Thus, most sexual abuse victims in the community, when evaluated in surveys, show up as slightly impaired or normal. It is possible, however, that some of the impairment associated with childhood molestation is not tapped by these survey evaluations.

Summarizing then, from studies of clinical and nonclinical populations, the findings concerning the trauma of child sexual abuse appear to be as

follows: In the immediate aftermath of sexual abuse, from one-fifth to two-fifths of abused children seen by clinicians manifest pathological disturbance (Tufts, 1984). When studied as adults, victims as a group demonstrate impairment when compared with their nonvictimized counterparts, but under one-fifth evidence serious psychopathology. These findings give reassurance to victims that extreme long-term effects are not inevitable. Nonetheless, they also suggest that the risk of initial and long-term mental health impairment for victims of child sexual abuse should be taken very seriously.

Effects by Type of Abuse

Although the foregoing sections have been concerned with the various effects of abuse, there are also important research questions concerning the effects of various kinds of abuse. These have usually appeared in the form of speculation about what types of abuse have the most serious impact on victims. Groth (1978), for example, on the basis of his clinical experience, contended that the greatest trauma occurs in sexual abuse that (a) continues for a longer period of time, (b) occurs with a more closely related person, (c) involves penetration and (d) is accompanied by aggression. To that list, MacFarlane (1978) added experiences in which (e) the child participates to some degree, (f) the parents have an unsupportive reaction to disclosure of the abuse and (g) the child is older and thus cognizant of the cultural taboos that have been violated. Such speculations offer fruitful directions for research. Unfortunately, however, only a few studies on the effects of sexual abuse have had enough cases and been sophisticated enough methodologically to look at these questions empirically. Furthermore, the studies addressing these issues have reached little consensus in their findings.

Duration and Frequency of Abuse

Although many clinicians take for granted that the longer an experience goes on, the more traumatic it is, this conclusion is not clearly supported by the available studies. Of nine studies, only four found duration associated with greater trauma. (We are treating duration and frequency synonymously here because they tend to be so highly correlated.) Three found no relation and two even found some evidence that longer duration is associated with less trauma.

Russell's (in press) study reported the clearest association: In her survey of adult women, 73% of sexual abuse that lasted for more than 5 years was self-rated as extremely or considerably traumatic by the victims, compared with 62% of abuse lasting 1 week to 5 years and 46% of abuse occurring only once. Tsai et al., (1979) found duration and frequency associated with greater negative effects, when measured with the Minnesota Multiphasic Personality Inventory and a problems checklist, at least in their group of adult sexual abuse victims who sought counseling. Bagley and Ramsay (1985) found that the general mental health status of adult victims -- measured by a composite of indicators concerning depression, psychoneurosis, suicidal ideation, psychiatric consultation and self-concept -- was worse for longer lasting experiences. Finally, Friedrich, Urguiza and Beilke (in press), studying children, found that both duration and frequency predicted disturbances measured by the CBCL, even in multivariate analysis.

However, other studies have not found such relations. Finkelhor (1979), in a retrospective survey of college students, used a self-rating of how negative the experience was in retrospect and found no association with duration. Langmade (1983) reported that adult women seeking treatment who had had long or short duration experiences did not differ on measures of sexual anxiety, sexual guilt, or sexual dissatisfaction. In addition, the Tufts (1984) study, looking at child victims with more comprehensive measures than Friedrich et al., (in press), could find no association between duration of abuse and measures of distress, using the Louisville Behavior Checklist and the Purdue Self-Concept Scale, as well as other measures.

Finally, some studies indicated a completely reversed relation. Courtois (1979), surprisingly, found that adult victims with the longest lasting experiences reported the least trauma. In addition, in their college student sample, Seidner and Calhoun (1984) reported that a high frequency of abuse was associated with higher self-acceptance (but lower social maturity) scores on the California Psychological Inventory.

In summary, then, the available studies reach quite contradictory conclusions about the relation between duration and trauma. However, duration is closely related to other aspects of the abuse experience -- e.g., age at onset, a family relationship between victim and offender and the nature of the sexual activity. Some of the contradictions may be cleared up when we have better studies with well-defined multivariate analyses that can accurately assess the independent effect of duration.

Relationship to the Offender

Popular and clinical wisdom holds that sexual abuse by a close relative is more traumatic than abuse by someone outside the family. Empirical findings suggest that this may be the case at least for some types of family abuse. Three studies have found more trauma resulting from abuse by relatives than by nonrelatives: Landis (1956), in an early study asking students about how they had recovered; Anderson et al., (1981), in a chart review of adolescents in a hospital treatment setting; and Friedrich et al., (in press), in their evaluation of young victims. However, other researchers (Finkelhor, 1979; Russell, in press; Seidner and Calhoun, 1984; Tufts, 1984) found no difference in the impact of abuse by family members versus abuse by others.

It must be kept in mind that how closely related a victim is to the offender does not necessarily reflect how much betrayal is involved in the abuse. Abuse by a trusted neighbor may be more devastating than abuse by a distant uncle or grandfather. Also, whereas abuse by a trusted person involves betrayal, abuse by a stranger or more distant person may involve more fear and thus be rated more negatively. These factors may help explain why the relative-nonrelative distinction is not necessarily a consistent predictor of trauma.

What has been more consistently reported is greater trauma from experiences involving fathers or father figures compared with all other types of perpetrators, when these have been separated out. Russell (in press) and Finkelhor (1979) both found that abuse by a father or stepfather was significantly more traumatic for victims than other abuse occurring either inside or

outside the family. The Tufts (1984) study also reported that children abused by stepfathers showed more distress, but for some reason it did not find the same elevated level of distress among victims abused by natural fathers. Bagley and Ramsay (1985) found a small but nonsignificantly greater amount of impairment in women molested by fathers and stepfathers.

Type of Sexual Act

Results of empirical studies generally suggest, with a couple of important exceptions, that the type of sexual activity is related to the degree of trauma in victims. Russell's findings on long-term effects in adult women are the most clear-cut: Fifty-nine percent of those reporting completed or attempted intercourse, fellatio, cunnilingus, analingus, or anal intercourse said they were extremely traumatized, compared with only 36% of those who experienced manual touching of unclothed breasts or genitals and 22% of those who reported unwanted kissing or touching of clothed parts of the body. The community study by Bagley and Ramsay (1985) confirms this, in a multi-variate analysis that found penetration to be the single most powerful variable explaining severity of mental health impairment, using a composite of standardized instruments.

Moreover, four other studies confirm the relation between type of sexual contact and subsequent effects by demonstrating that the least serious forms of sexual contact are associated with less trauma (Landis, 1956; S. Peters, 1984; Seidner and Calhoun, 1984; Tufts, 1984). However, some of these studies did not find the clear differentiation that Russell and Bagley and Ramsay did between intercourse and genital touching. The Tufts (1984) study, for example, using measures of children's anxiety, found children who had been fondled without penetration to be more anxious than those who actually suffered penetration. Moreover, there are three additional studies (Anderson et al., 1981; Finkelhor, 1979; Fromuth, 1983) that do not show any consistent relation between type of sexual activity and effect. Thus, a number of studies concur that molestation involving more intimate contact is more traumatic than less intimate contact. However, there is some disagreement about whether intercourse and penetration are demonstrably more serious than simple manual contact.

Force and Aggression

Five studies, three of which had difficulty finding expected associations between trauma and many other variables, did find an association between trauma and the presence of force. With Finkelhor's (1979) student samples, use of force by an abuser explained more of a victim's negative reactions than any other variable and this finding held up in multivariate analysis. Fromuth (1983), in a replication of the Finkelhor study, found similar results. In Russell's (in press) study 71% of the victims of force rated themselves as extremely or considerably traumatized, compared with 47% of the other victims.

The Tufts (1984) study found force to be one of the few variables associated with children's initial reactions: Children subjected to coercive experiences showed greater hostility and were more fearful of aggressive

behavior in others. Tufts researchers reported that physical injury (i.e., the consequence of force) was the aspect of sexual abuse that was most consistently related to the degree of behavioral disturbances manifested in the child, as indicated by the LBC and other measures. Similarly, Friedrich et al., (in press) found the use of physical force to be strongly correlated with both internalizing and externalizing symptoms on the CBCL.

Three other studies present dissenting findings, however. Anderson et al., (1981), in studying initial effects, concluded that, "the degree of force or coercion used did not appear to be related to presence or absence of psychosocial sequelae" in the adolescents they evaluated (p. 7). Seidner and Calhoun (1984), in an ambiguous finding, noted that force was associated with lower social maturity but higher self-acceptance. In addition, Bagley and Ramsay (1985) found that force was associated with greater impairment, but this association diminished to just below the significance level in multivariate analysis. Despite these findings, we are inclined to give credence to the studies showing force to be a major traumagenic influence, especially given the strong relation found by Finkelhor, Friedrich et al., Fromuth, Russell and the Tufts study. Although some have argued that victims of forced abuse should suffer less long-term trauma because they could more easily attribute blame for abuse to the abuser (MacFarlane, 1978), empirical studies do not seem to provide support for this supposition.

Age at Onset

There has been a continuing controversy in the literature about how a child's age might affect his or her reactions to a sexually abusive experience. Some have contended that younger children are more vulnerable to trauma because of their impressionability. Others have felt that their naiveté may protect them from some negative effects, especially if they are ignorant of the social stigma surrounding the kind of victimization they have suffered. Unfortunately, findings from the available studies do not resolve this dispute.

Two studies of long-term effects do suggest that younger children are somewhat more vulnerable to trauma. Meiselman (1978), in her chart review of adults in treatment, found that 37% of those who experienced incest prior to puberty were seriously disturbed, compared with only 17% of those who were victimized after puberty. Similarly, Courtois (1979), in her community sample, assessed the impact of child sexual abuse on long-term relationships with men and the women's sense of self and also found more effects from prepubertal experiences.

However, four other studies found no significant relation between age at onset and impact. Finkelhor (1979), in a multivariate analysis, found a small but nonsignificant tendency for younger age to be associated with trauma. Russell (in press) also found a small but nonsignificant trend for experiences before age 9 to be associated with more long-term trauma. Langmade (1983) could find no difference in sexual anxiety, sexual guilt, or sexual dissatisfaction in adults related to the age at which they were abused. Bagley and Ramsay (1985) found an association between younger age and trauma, but that association dropped out in multivariate analysis, especially when controlling for acts involving penetration.

The Tufts (1984) study gave particular attention to children's reactions to abuse at different ages. Tufts researchers concluded that age at onset bore no systematic relation to the degree of disturbance. They did note that latency-age children were the most disturbed, but this finding appeared more related to the age at which the children were evaluated than the age at which they were first abused. They concluded that the age at which abuse begins may be less important than the stages of development through which the abuse persists.

In summary, studies tend to show little clear relation between age of onset and trauma, especially when they control for other factors. If there is a trend, it is for abuse at younger ages to be more traumatic. Both of the initial hypotheses about age of onset may have some validity, however: Some younger children may be protected by naiveté, whereas others are more seriously traumatized by impressionability. However, age interacts with other factors like relationship to offender and until more sophisticated analytical studies are done, we cannot say whether these current findings of a weak relation mean that age has little independent effect or is simply still masked in complexity.

Sex of Offender

Perhaps because there are so few female offenders (Finkelhor and Russell, 1984), very few studies have looked at impact according to the sex of the offender. Two studies that did (Finkelhor, 1984; Russell, in press) both found that adults rated experiences with male perpetrators as being much more traumatic than those with female perpetrators. A third study (Seidner and Calhoun, 1984) found male perpetrators linked with lower self-acceptance, but higher social maturity, in college-age victims.

Adolescent and Adult Perpetrators

There are also very few studies that have looked at the question of whether age of the perpetrator makes any difference in the impact of sexual abuse on victims. However, two studies using college student samples (Finkelhor, 1979; Fromuth, 1983) found that victims felt significantly more traumatized when abused by older perpetrators. In Finkelhor's multivariate analysis (which controlled for other factors such as force, sex of perpetrator, type of sex act and age of the offender), age of the offender was the second most important factor predicting trauma. Fromuth (1983) replicated these findings. Russell (in press), with a community sample, reported consistent, but qualifying results: In her survey, lower levels of trauma were reported for abuse with perpetrators who were younger than 26 or older than 50. The conclusion that experiences with adolescent perpetrators are less traumatic seems supported by all three studies.

Telling or Not Telling

There is a general clinical assumption that children who feel compelled to keep the abuse a secret in the aftermath suffer greater psychic distress as a result. However, studies have not confirmed this theory. Bagley and Ramsay (1985) did find a simple zero-order relation between not telling and a

composite measure of impairment based on depression, suicidal ideas, psychiatric consultation and self-esteem. However, the association became nonsignificant when controlled for other factors. Finkelhor (1979), in a multivariate analysis, also found that telling or not telling was essentially unrelated to a self-rated sense of trauma. Further, the Tufts (1984) researchers, evaluating child subjects, reported that the children who had taken a long time to disclose the abuse had the least anxiety and the least hostility. Undoubtedly, the decision to disclose is related to many factors about the experience, which prevents a clear assessment of its effects alone. For example, although silence may cause suffering for a child, social reactions to disclosure may be less intense if the event is long past. Moreover, the conditions for disclosure may be substantially different for the current generation than they were for past generations. Thus, any good empirical evaluation of the effects of disclosure versus secrecy needs to take into account the possibility of many interrelationships.

Parental Reaction

Only two studies have looked at children's trauma as a function of parental reaction, even though this is often hypothesized to be related to trauma. The Tufts (1984) study found that when mothers reacted to disclosure with anger and punishment, children manifested more behavioral disturbances. However, the same study did not find that positive responses by mothers were systematically related to better adjustment. Negative responses seemed to aggravate, but positive responses did not ameliorate, the trauma. Anderson et al., (1981) found similar results: They noted 2½ times the number of symptoms in the children who had encountered negative reactions from their parents. Thus, although only based on two studies of initial effects, the available evidence indicates that negative parental reactions aggravate trauma in sexually abused children.

Institutional Response

There is a great deal of interest in how institutional response may affect children's reactions to abuse, but little research has been done. Tufts (1984) researchers found that children removed from their homes following sexual abuse exhibited more overall behavior problems, particularly aggression, than children who remained with their families. However, the children who were removed in the Tufts study were also children who had experienced negative reactions from their mothers, so this result may be confounded with other factors related to the home environment.

Summary of Contributing Factors

From this review of empirical studies, it would appear that there is no contributing factor that all studies agree on as being consistently associated with a worse prognosis. However, there are trends in the findings. The preponderance of studies indicate that abuse by fathers or stepfathers has a more negative impact than abuse by other perpetrators. Experiences involving genital contact seem to be more serious. Presence of force seems to result in more trauma for the victim. In addition, when the perpetrators are men rather than women and adults rather than teenagers, the effects of sexual abuse

appear to be more disturbing. These findings should be considered tentative, however, being based on only two studies apiece. When families are unsupportive of the victims and/or victims are removed from their homes, the prognosis has also been shown to be worse; again, these findings are based on only two studies.

Concerning the age of onset, the more sophisticated studies found no significant relation, especially when controlling for other factors; however, the relation between age and trauma is especially complex and has not yet been carefully studied. In regard to the impact of revealing the abuse, as opposed to the child keeping it a secret, current studies also suggest no simple relation. Of all these areas, there is the least consensus on the effect of duration of abuse on impact.

Discussion

Conclusions from the foregoing review must be tempered by the fact that they are based on a body of research that is still in its infancy. Most of the available studies have sample, design and measurement problems that could invalidate their findings. The study of the sexual abuse of children would greatly benefit from some basic methodological improvements.

Samples. Many of the available studies are based on samples of either adult women seeking treatment or children whose molestation has been reported. These subjects may be very self-selected. Especially if sexual abuse is so stigmatizing that only the most serious cases are discovered and only the most seriously affected victims seek help, such samples could distort our sense of the pathology most victims experience as a result of this abuse. New studies should take pains to expand the size and diversity of their samples and particularly to study victims who have not sought treatment or been reported. Advertising in the media for "well-adjusted" victims, as Tsai et al. (1979) did, however, does not seem an adequate solution, as this injects a different selection bias into the study.

We favor sampling for sexual abuse victims within the general population, using whole communities -- as in Russell's (in press), S. Peters's (1984) and Bagley and Ramsay's (1985) designs -- or other natural collectivities (high school students, college students, persons belonging to a health plan, etc.). Obtaining such samples may be easier with adult than with child victims. If identified child victims must be used, care should be taken to sample from all such identified children, not just the ones that get referred for clinical assessment and treatment and who may therefore represent the most traumatized group.

Control groups. Some of the empirical studies cited here did not have comparison groups of any sort. Such a control is obviously important, even if it is only a group of other persons in treatment who were not sexually victimized (e.g., Briere, 1984; Meiselman, 1978). In some respects, however, this control procedure may actually underestimate the types and severities of pathology associated with sexual abuse, because problems that sexual abuse victims share with other clinical populations will not show up as distinctive effects. An as yet untried, but we believe fruitful, approach is to match

victims from clinical sources with other persons who grew up with them: that is, schoolmates, relatives, or even unvictimized siblings.

Measurement. Most of the studies we reviewed used fairly subjective measures of the outcome variables in question (e.g., guilt feelings, fears, etc.). We are encouraged by the appearance of studies such as the Tufts study and Bagley and Ramsay's survey, which used batteries of objective measures. However, empirical investigations need to go even further. To test for the specific and diverse sequelae that have been associated with child sexual abuse, it would appear that special sexual abuse outcome instruments now need to be developed. Instruments designed specifically to measure the after-effects noted by clinicians might be more successful at showing the true extent of pathology related to the experience of sexual abuse in childhood.

Sexual abuse in deviant subpopulations. Some of the studies purporting to show effects of child sexual abuse are actually reports of prevalence among specialized populations, such as prostitutes (James and Meyerding, 1977; Silbert and Pines, 1981), sex offenders (Groth and Burgess, 1979), or psychiatric patients (Carmen, Rieker and Mills, 1984). To conclude from high rates of abuse in deviant populations that sexual abuse causes the deviance can be a misleading inference. Care needs to be taken to demonstrate that the discovered rate of sexual abuse in the deviant group is actually greater than in a relevant comparison group. In at least one study of sex offenders, for example, although abuse was frequent in their backgrounds, even higher rates of prior abuse were found for prisoners who had not committed sex crimes (Gebhard, Gagnon, Pomeroy and Christenson, 1965). It is important to recognize that such data do not indicate that sexual abuse caused the deviance, only that many such offenders have abuse in their backgrounds.

Developmentally specific effects. In studying the initial and long-term effects of sexual abuse, researchers must also keep in mind that some effects of the molestation may be delayed. Although no sexual difficulties may be manifest in a group of college student victims (as in Fromuth, 1983), such effects may be yet to appear and may manifest themselves in studies of older groups. Similarly, developmentally specific effects may be seen among children that do not persist into adulthood, or that may assume a different form as an individual matures. The Tufts (1984) study clearly demonstrated the usefulness of looking at effects by defined age groupings.

Disentangling sources of trauma. One of the most imposing challenges for researchers is to explore the sources of trauma in sexual abuse. Some of the apparent effects of sexual abuse may be due to premorbid conditions, such as family conflict or emotional neglect, that actually contributed to a vulnerability to abuse and exacerbated later trauma. Other effects may be due less to the experience itself than to later social reactions to disclosure. Such questions need to be approached using careful multivariate analyses in large and diverse samples, or in small studies that match cases of sexual abuse that are similar except for one or two factors. Unfortunately, these questions are difficult to address in retrospective long-term impact studies, as it may be difficult or impossible to get accurate information about some of the key variables (e.g., how much family pathology predated the abuse).

Preoccupation with long-term effects. Finally, there is an unfortunate tendency in interpreting the effects of sexual abuse (as well as in studies of other childhood trauma) to overemphasize long-term impact as the ultimate criterion. Effects seem to be considered less "serious" if their impact is transient and disappears in the course of development. However, this tendency to assess everything in terms of its long-term effect betrays an "adultocentric" bias. Adult traumas such as rape are not assessed ultimately in terms of whether they will have an impact on old age: They are acknowledged to be painful and alarming events, whether their impact lasts 1 year or 10. Similarly, childhood traumas should not be dismissed because no "long-term effects" can be demonstrated. Child sexual abuse needs to be recognized as a serious problem of childhood, if only for the immediate pain, confusion and upset that can ensue.

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